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481—63.14(135C) Records.

63.14(1) Resident record. The licensee shall keep a permanent record on all residents admitted to a specialized residential care facility with all entries current, dated, and signed. (III) The record shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Primary care provider's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortuary's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address; (III)
- j. Physical examination and medical history; (III)
- k. Certification by the primary care provider that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- *l.* Primary care provider's orders for medication, treatment, and diet in writing and signed by the primary care provider; (III)
 - m. A notation of yearly or other visits to primary care provider or other professional services; (III)
 - n. Any change in the resident's condition; (II, III)
- o. If the primary care provider has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medication, treatments, and diet prescribed by the primary care provider for each resident; (III)
- p. If the primary care provider has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration, including a medication manager or certified medication aide; (II)
- q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)
 - r. A notation describing the resident's condition on admission, transfer, and discharge; (III)
- s. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and primary care provider were notified of the resident's death; (III)
- t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
 - u. Disposition of valuables; (III)
 - v. Current individual program plans. (II, III)

63.14(2) Confidentiality of resident records.

- a. Each resident shall be ensured confidential treatment of all information contained in the resident's records. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)
- b. The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)
- c. Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

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d. The resident or the resident's responsible party shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the primary care provider determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted before the record is made available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

63.14(3) Incident record.

- a. Each residential care facility shall maintain an incident record report and shall have available incident report forms. (II, III)
 - b. Report of incidents shall be in detail on an incident report form. (III)
- c. The person in charge at the time of the incident shall oversee the preparation of and sign the incident report. The administrator or designee shall review, sign and date the incident report within 72 hours of the accident, incident or unusual occurrence. (II, III)
- d. An incident report shall be completed for every accident or incident where there is apparent injury or where an injury of unknown origin may have occurred. (II)
- e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III)
 - f. A copy of the incident report shall be kept on file in the facility. (II, III)

63.14(4) Retention of records.

- a. Records shall be retained in the facility for five years following the termination of services to a resident. (III)
 - b. Records shall be retained within the facility upon change of ownership. (III)
- c. When the facility ceases to operate, a copy of the resident's record shall be released to the facility to which the resident is transferred. (III)
- d. When the facility ceases to operate, records shall be maintained for five years in a clean, dry secured storage area. (III)
- **63.14(5)** *Electronic records.* In addition to the access provided in 481—subrule 50.10(2), an authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the residents of the facility. (II, III)
- a. If access to an electronic record is requested by the authorized representative of the department, the facility may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion. (II, III)
- b. The facility shall provide a terminal where the authorized representative may access records. (II, III)
- c. If the facility is unable to provide direct print capability to the authorized representative, the facility shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation. (II, III)
- **63.14(6)** Reports to the department. The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

63.14(7) Personnel record.

- a. Personnel records for each employee shall be kept in accordance with subrule 63.8(4). (III)
- b. The personnel records shall be made available for review upon request by the department. (III) [ARC 3740C, IAB 4/11/18, effective 5/16/18]